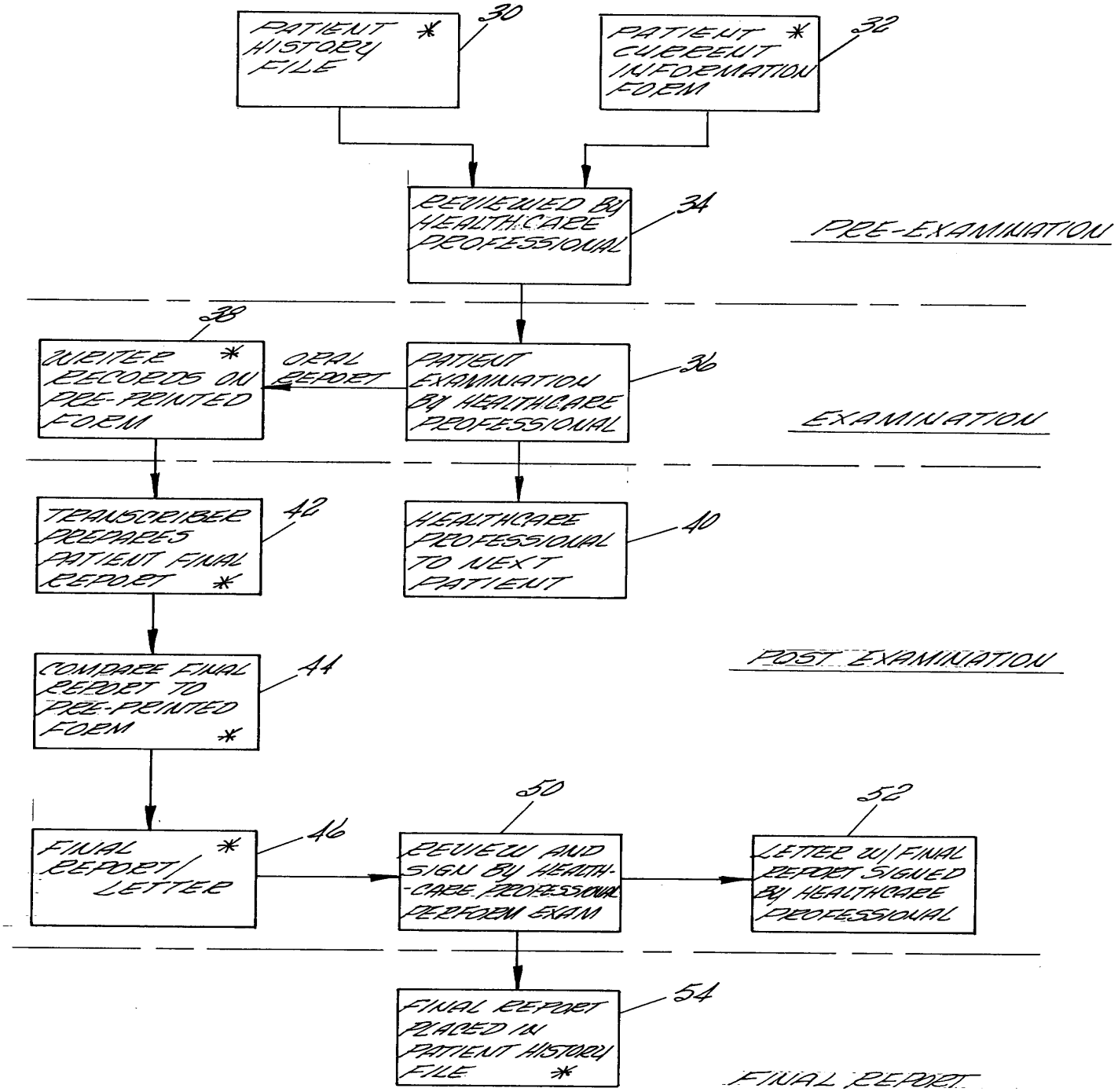


* THESE FUNCTIONS CAN BE PERFORMED WITH A COMPUTER INPUT DEVICE, COMPUTER & SOFTWARE

FIG 1

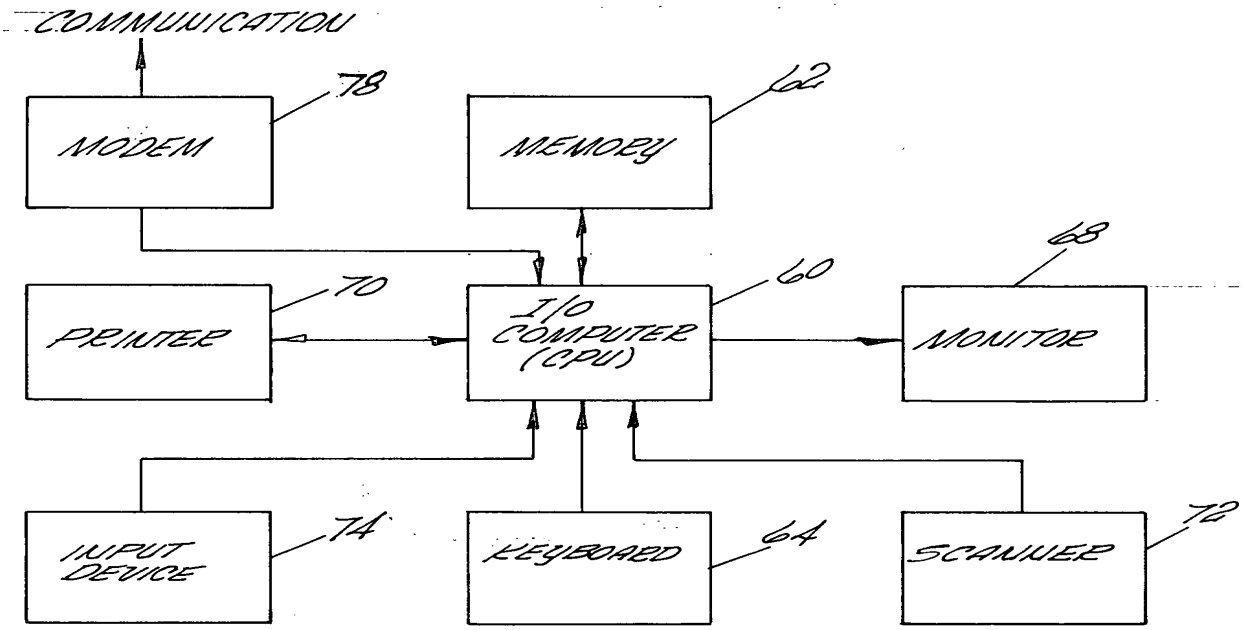


Fig 2

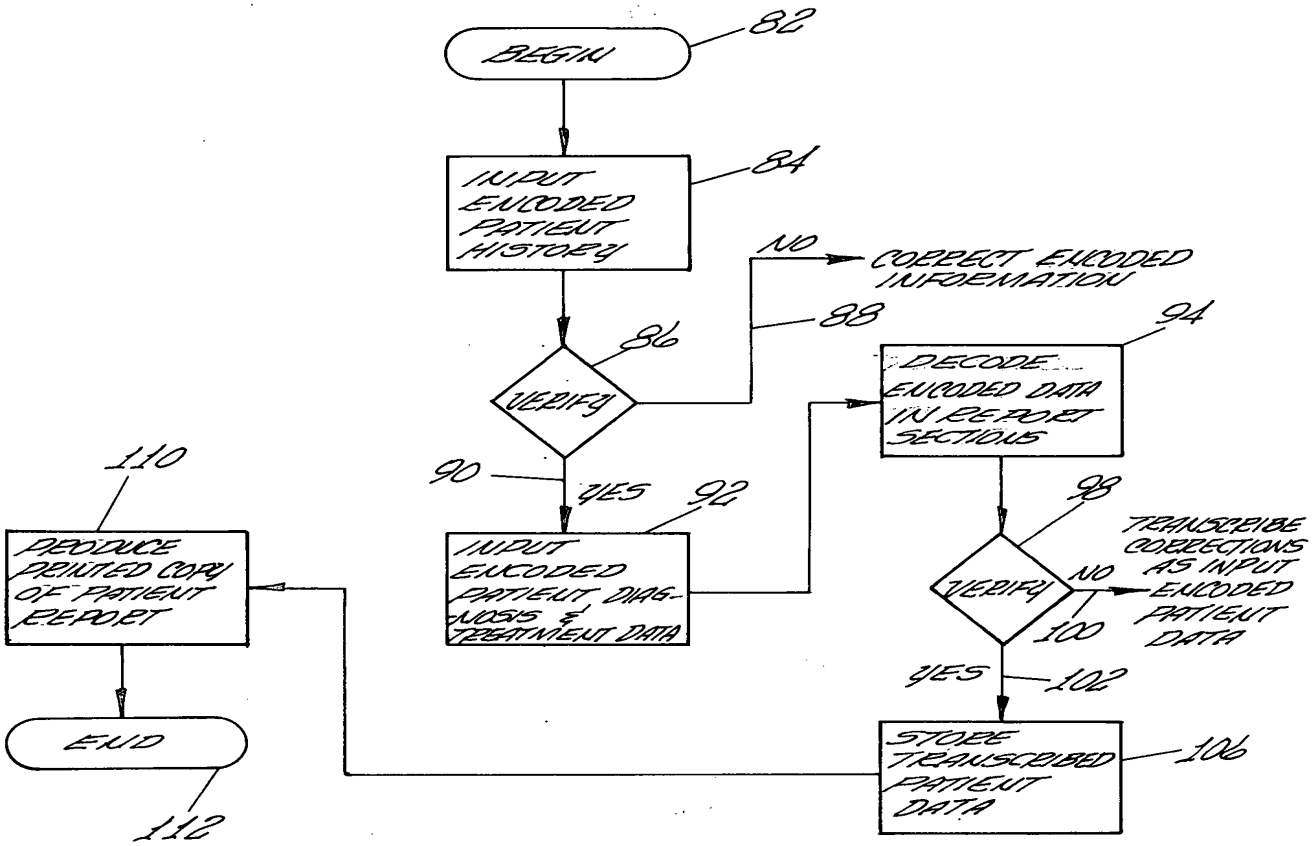


Fig 3

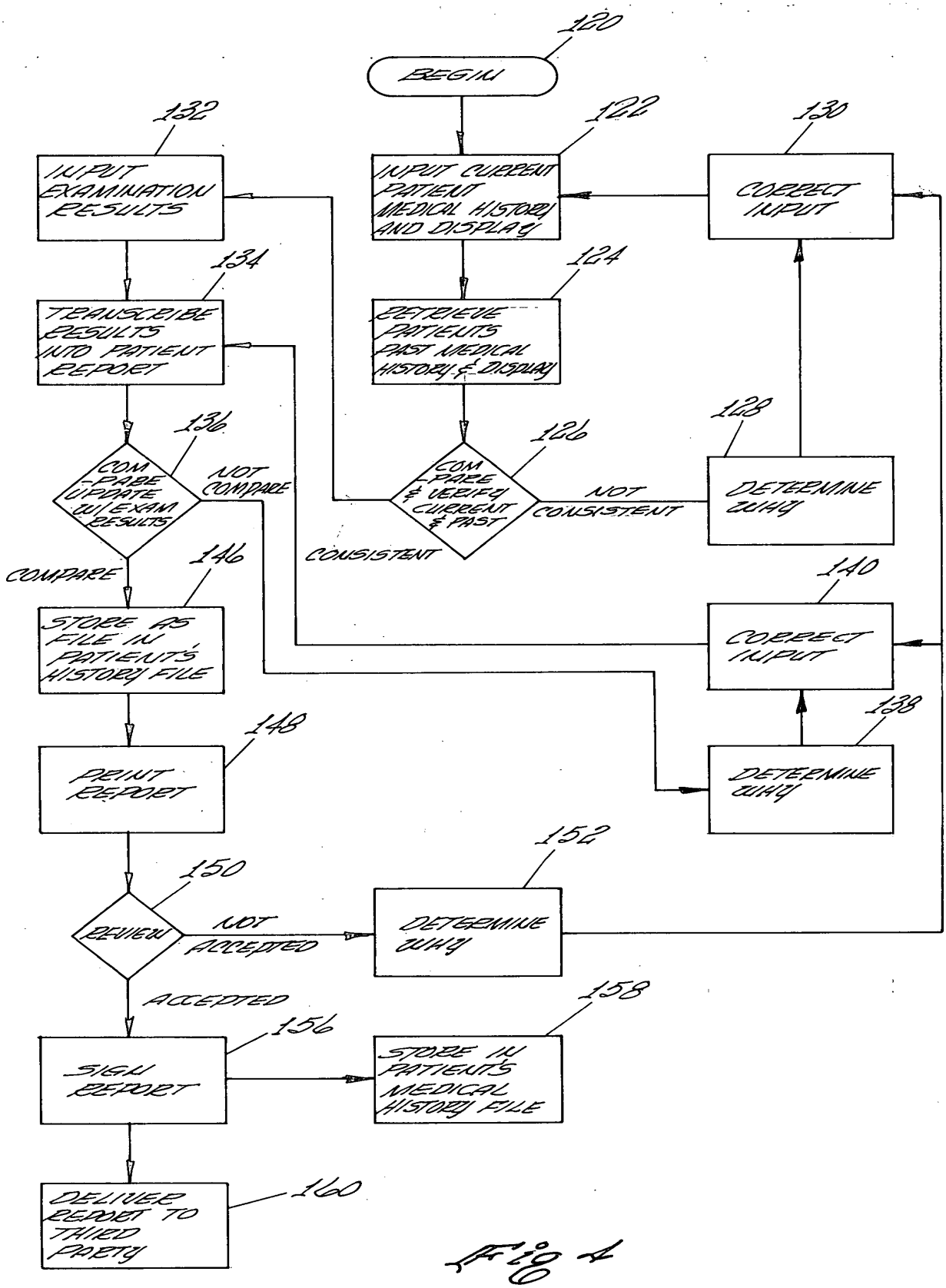


FIG 4

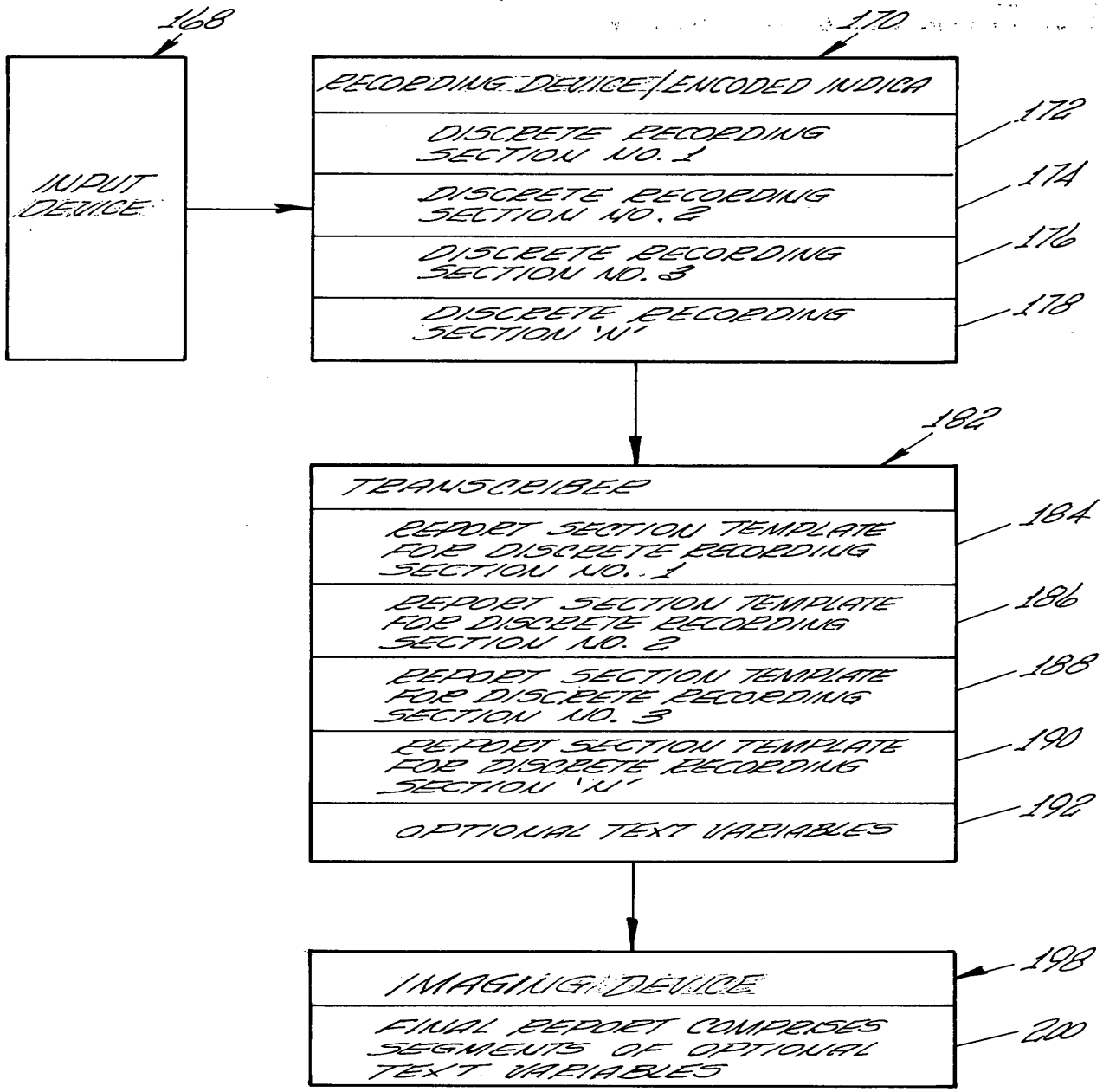


Fig 5

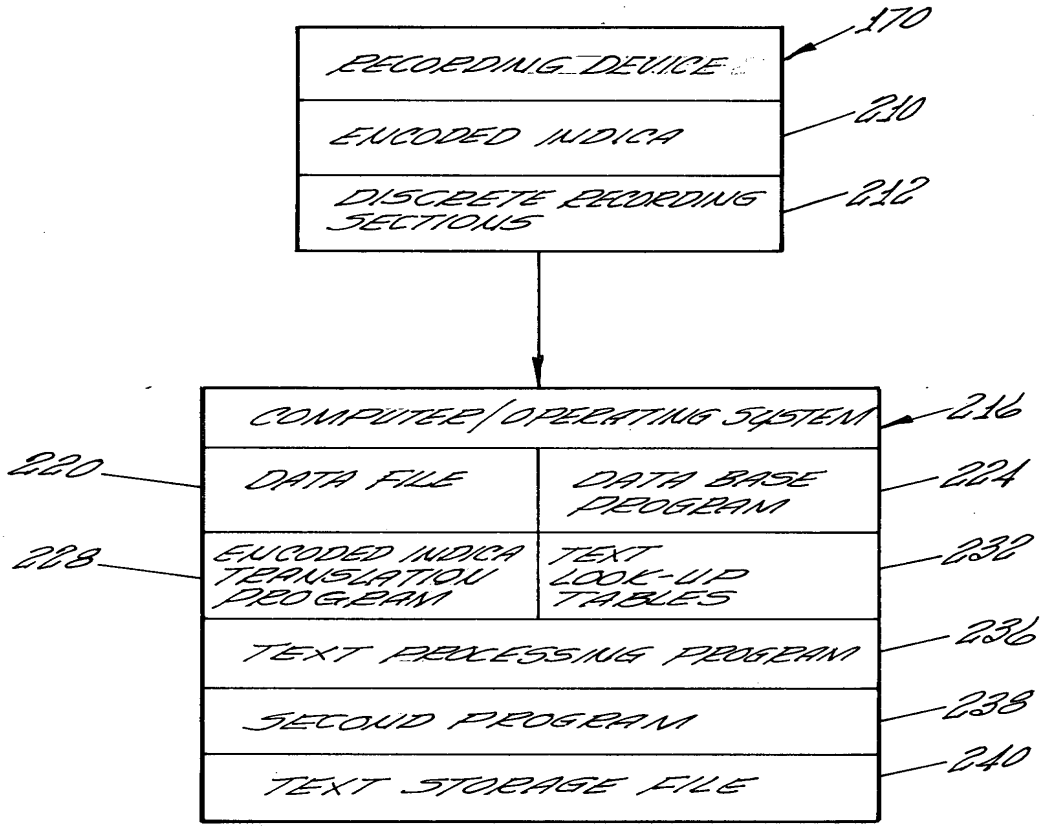


Fig 6

252

Name:
Age:
M F CH#
Ht: Wt: P: R: Temp: LMP
Date
w/u wr prov

250

CC:

BP L R
St
Si
Ly

Allergies:

Rec Lab:

Circle any examined, note norms Enter # of abn, indicate findings

1. Gen, skin:
2. HEENT:
3. Neck:
4. Heart:
5. Lungs: wheezes ronchi rales
6. Breasts:
7. Abdomen: tend, mass, bs + -
   guarding, rebound
8. Rectal:
9. Pelv (F):
   Genital (M):
10. Musc-skel:
    TP
11. Neuro: reflexes
12. Other:

254

Lab: RBS FBS HgbA1c CBC Renal Lipid SMAC UA Thy TSH
WtMt Pap Chlam Gc RPR HIV ESR Other:

X-ray U/S CT MRI of mammo other:

Assessment:	Plan:
1	1
2	2
3	3
4	4

[] see med list

RTC D W M Y for | Ref F T

256 258

Fig 7

266

NAME: DATE: ANNUAL and NEW PATIENT

[] New Patient NKL Last Pap: ____
[] Annual Class: ____

Current problems:

Current Medications:

Treated by another physician:
Who and why:

Past medical history:

FOR ANNUAL ONLY:
Any serious illness or operations in the past year:
Any family members seriously ill in past year:

IMPRESSION:
1. 4.
2. 5.
3. 6.

PLAN: [] Mammogram [] TOC in 10 days

Meds: _____

Procedures: _____

Other:

Return to clinic: [] 6 months
[] 1 year

For recheck in ____ [] days [] weeks
[] months

BIRTH CONTROL METHOD
Name of Pill: _____ [] 28 [] 21
[] BCP
[] condoms OTC [] diaph.
[] none needed

[] Premarin .625 # 100 x 1 ____
.9 # 100 x 1 ____
1.25 # 100 x 1 ____
[] 1 po qd
[] 1 po qd 1-25 cycle

[] Provera 10 mg # 30 x 1 refill
[] Norethindrone acet 5 mg # 30 x 1
[] 1 po qd 16-25 cycle

270

Fig 8

APPROVED
BY
DRAFTSMAN
O.G. FIG.
CLASS
SUBCLASS

274

NAME: DATE: INIT

Last Pap:

Purpose of this visit:

Signs/Symptoms:

276

Prior Tx.:
Other information:

Current Medications:

EXAM	AGE:	WT:	BP /	LMP: / /	G __ P __ A __ T __

HEENT	HEART	LUNGS	R L BREAST	ABDOMEN	RECTAL
[] WNL	[] reg	[][] clear	[][] ø mass	[] soft/nt	[] WNL
[] ery RTM	[] irreg	[][] wheezes	[][] FCB	[] epigastr	[] confir
[] ery LTM	[] murmur	[][] rales	[][] mass	[] LUQ/LLQ	[] hemorr
[] ery phary	[]	[][] < BS	[][] lger	[] RUQ/RLQ	
[] lge nodes	[]	[][]	[][] other	[] general	

280

VULVA	VAGINA	CERVIX	UTERUS	R L ADNEXA
[] WNL	[] WNL(supple)	[] pk/smth	[] Normal (NSSC)	[][] nontende
[] erythema	[] erythema	[] ectropian	[] tender	[][] ø masses
[] atropic	[] discharge	[] inflamed	[] enlgd ___wks	[][] tender
[] condyloma	[] S. H. L	[] friable	[] congested	[][] enlarged
[] lesions	[] old b/red	[] lesion	[] fibroids	[][] mass ___cm
[] other	[] atropic	[] other	[] other	[][] other: ___
	[] other	[] Pap		

OFFICE PROCEDURES

282

UA	Wet Mount
[] neg dip	[] yeast
[] neg spin	[] > wbc
[] WBC	[] clue cell
[] blood	[] mixed
[] protein	
[] nitrites	
[] other	

ASSESSMENT: 1. 4.
2. 5.
3. 6.

286

PLAN: Lab: [] HGP [] Uricult [] Strep [] Infert. Panel day ___
[] Mammo [] TOC 10 days [] Other: _____

Meds:

Procedure:

Other:

288

RTC: [] ___ days / wks / mos reck [] Pap & phy in ____

Fig 9

292

NEW PATIENT HISTORY
OR
ESTABLISHED PATIENT WITH A NEW INJURY

Name: _____

___ W/C ___ P/I ___ Home Related ___ Sports Related ___ School

History of the Injury:

Injured area: _____

When: _____

Where: _____

Injury as it occurred:

Where treated:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Tests, x-rays and/or surgeries done:

_____

_____

_____

Referred By: _____

Fig 10

300

PATIENT INFORMATION SHEET (NEW W/C RETURN POST-OP OSTEO)

SURGERY: Type:_____Date_____

Last Name:_____
First Name:_____
Race: O SP-C C N Male Female
Job Description:_____
Requires: Bending Stooping Twisting Reaching Standing Walking
Working overhead Lifting Sitting Kneeling
ALLERGIES: NKA
_____
CURRENT MEDICATIONS: NONE
_____
SHOULD THIS REPORT BE IN LETTER STYLE? yes no
If yes, where should additional letter be sent?
Attorney_____ Referring Physician_____ Other_____
_____
Which body part(s) are injured?
Cervical spine, Shoulder, Elbow, Wrist, Hand, Fingers,
Thoracic spine, Lumbar spine, Hip, Knee, Ankle, Foot, Toe

Date of last visit:_____
Prior Tests and results:_____
Medication since last visit:_____
Physical Therapy since last visit:_____
Does the patient have pain which awakens them at night? yes no
If yes, number of times:_____

ACTIVITY RECORD (W/C ONLY)

Patient can do the following:
Sit for _____hrs _____mins.
Stand for _____hrs _____min
Walk for _____hrs _____min
Ride in Car ____hrs _____min

Lift _____lbs
Kneel N O F
Climb N O F
Bend N O F
Twist N O F

PAIN DESCRIPTION: _____ R L RL
Pain Description: Throbbing, Stabbing Burning Dull/Aching
Sharp
Radiation (Cervical and Lumbar): Shoulder R/L Arm R/L Hand R/L
Buttock R/L Thigh R/L Calf R/L Foot R/L
Pain made worse with cough or sneeze? yes no
Loss of control of bowel or bladder? yes no
Other symptoms: Inability to bear weight, Popping, Stiffness,
Swelling, Cramping, Heaviness, Numbness, Tingling, Soreness
Change since last visit: Improved Unchanged Worse
Has had this pain before: yes no multiple times once years ago
Pain made worse by: sitting Standing Walking Riding in a car
Lifting Twisting Working overhead Bending
Pain improved by: Rest Heat Ice Medication Physical therapy
Chiropractic treatments Home exercise program

Fig 11

302

PAIN DESCRIPTION: _____ R L RL
Pain description: Throbbing Stabbing Burning Dull/Aching

Radiation (Cervical and Lumbar) : Shoulder R/L Arm R/L Hand R/L
Buttock R/L Thigh R/L Calf R/L Foot R/L
Pain is made worse with cough or sneeze? yes no
Loss of control of bowel or bladder? yes no
Other symptoms: Inability to bear weight, Popping, Stiffness,
Swelling, Cramping, Heaviness, Numbness, Tingling, Soreness
Change since last visit: Improved Unchanged Worse
Has had this pain before: yes no multiple times once years ago
Pain made worse by: Sitting, Standing, Walking, Riding in a car
Lifting, Twisting, Working overhead, Bending
Pain improved by: Rest Heat Ice Medication Physical therapy
Chiropractic treatments Home exercise program

PAIN DESCRIPTION: _____ R L RL
Pain description: Throbbing Stabbing Burning Dull/Aching
Sharp
Radiation (Cervical and Lumbar) : Shoulder R/L Arm R/L Hand R/L
Buttock R/L Thigh R/L Calf R/L Foot R/L
Pain is made worse with cough or sneeze? yes no
Loss of control of bowel or bladder? yes no
Other symptoms: Inability to bear weight, Popping, Stiffness,
Swelling, Cramping, Heaviness, Numbness, Tingling, Soreness
Change since last visit: Improved Unchanged Worse
Has had this pain before: yes no multiple times once years ago
Pain made worse by: Sitting, Standing, Walking, Riding in a car
Lifting, Twisting, Working overhead, Bending
Pain improved by: Rest Heat Ice Medication Physical therapy
Chiropractic treatments Home exercise program

PHYSICAL EXAMINATION

Cervical spine
Shoulder
Elbow
Wrist
Hand
Thumb
Index finger
Long finger
Ring finger
Fifth finger
Strength upper
Reflex upper
Measurements upper
Pulses upper
Jaymar

Lumbar spine
Thoracic spine
Hips
Knees
Ankles and feet
Great toe
Second
Third
Fourth
Fifth
Straight leg raising
Measurements lower
Strength lower
Reflex lower

Pulses Lower
Osteo 1
Osteo 2
Osteo 3

Fig 12

APPROVED
BY
DRAFTSMAN
O.G. FIG.
CLASS
SUBCLASS

304

Areas of tenderness:
Areas of erythema:
Areas of swelling:
Areas of ecchymosis:

GENERAL APPEARANCE:

Cervical lordosis:	present/absent	
Muscle spasm:	present/absent	location _____
Contusions:	present/absent	
Scars:	present/absent	location _____

RANGE OF MOTION OF THE CERVICAL SPINE:

Flexion:	0-20
Extension:	0-20
Rotation (R):	0-90
Rotation (L):	0-90
Lateral bend (R):	0-20
Lateral bend (L):	0-20

SHOULDERS:	**RIGHT**	**LEFT**
Flexion:	0-180	0-180
Extension:	0-20	0-20
Abduction:	0-180	0-180
Adduction:	0-90	0-90
Internal rotation:	0-90	0-90
External rotation:	0-90	0-90
Crepitation:	neg	neg
Thumb to	_____	_____ in extension

ELBOWS:		
Flexion/Extension:	0-135	0-135
Supination:	0-90	0-90
Pronation:	0-90	0-90
Pain on extension of wrist	no	no
Pain on flexion of wrist	no	no

WRISTS AND HANDS:		
Flexion:	0-90	0-90
Extension:	0-90	0-90
Ulnar deviation:	0-35	0-35
Radial deviation:	0-15	0-15
Tinel's (cts)	neg	neg
Finkelstein's	neg	neg
Phalen's (cts)	neg	neg
O test:	neg	neg
Thenar atrophy (cts)	neg	neg
Hypothenar atrophy (cts)	neg	neg
Crepitation:	neg	neg
Palpable spurs:	no	no
Ganglions:		
volar	no	no
dorsal	no	no

Fig 13

306

THUMB AND FINGER:	**RIGHT**	**LEFT**
M. P.	0-90	0-90
Crepitation:	neg	neg
Palpable spurs:	neg	neg
Instability:	neg	neg
P. I. P.	0-90	0-90
Crepitation:	neg	neg
Palpable spurs:	neg	neg
Instability:	neg	neg
D. I. P.	0-90	0-90
Crepitation:	neg	neg
Palpable spurs:	neg	neg
Instability:	neg	neg
Trigger finger:	neg	neg

MUSCLE STRENGTH DETERMINATION:		
Deltoid - Ant.	5/5	5/5
Med.	5/5	5/5
Shoulder Int. rotation:	5/5	5/5
Shoulder Ext. rotation:	5/5	5/5
Biceps:	5/5	5/5
Triceps:	5/5	5/5
Brachial radialis:	5/5	5/5
Wrist flexors:	5/5	5/5
Finger flexors:	5/5	5/5
Finger extensors:	5/5	5/5
Intrinsics:	5/5	5/5

JAYMAR Grip strength:	/ / /	/ / /
Lateral pinch:	/ / /	/ / /
Chuck pinch:	/ / /	/ / /

REFLEX REACTION:	**RIGHT**	**LEFT**
Biceps:	2+	2+
Triceps:	2+	2+
Pectoral:	2+	2+
Brachial radialis:	2+	2+

SENSATION:	normal	normal

PULSES:	**RIGHT**	**LEFT**
Radial:	2+	2+
Ulnar:	2+	2+
Maintained with shoulder abduction:	yes	yes

MEASUREMENTS:	**RIGHT**	**LEFT**
Upper arm (5" above the olecranon):		
Lower arm (5" below the olecranon):		

Fig 14

308

Areas of tenderness:
Areas of erythema:
Areas of swelling:
Areas of ecchymosis:

LUMBAR SPINE:

GENERAL APPEARANCE:

Shoulder and Pelvis level:	yes/no
Lumbar lordosis:	present/absent
Scoliosis:	present/absent
Muscle spasms:	present/absent
Contusions:	present/absent
Scars:	present/absent
Toes/Heels:	yes/no
Squat and stand:	yes/no

RANGE OF MOTION OF THE LUMBAR SPINE:

Flexion:	0-90	_____" from floor
Extension:	0-30	
Left lateral bend:	0-30	
Right lateral bend:	0-30	
Left rotation:	0-90	
Right rotation:	0-90	

STRAIGHT LEG RAISING:	**RIGHT**	**LEFT**
Supine:	90 degrees	90 degrees
Sitting:	90 degrees	90 degrees
Lasegues:	negative	negative
Hamstring tightening	90	90 degrees

HIP EXAMINATION:	**RIGHT**	**LEFT**
Flexion:	0-130	0-130
Extension:	0-30	0-30
Abduction:	0-45	0-45
Adduction:	0-30	0-30
Internal rotation:	0-85	0-85
External rotation:	0-60	0-60
Crepitation:	absent	absent
Trendelenburg:	negative	negative

KNEE EXAMINATION:

Flexion/Extension:	0-135	0-135
Effusion:	0	0
Anterior cruciate:	stable	stable
Posterior cruciate:	stable	stable
Medial collateral:	stable	stable
Lateral collateral:	stable	stable
McMurray's:	negative	negative
Lochman's:	negative	negative
Pivot shift:	negative	negative
Patellofemoral crepitation:	0/4+	0/4+
Tenderness:		
Medial joint line:	0/4+	0/4+
Lateral joint line:	0/4+	0/4+
Peripatellar:	0/4+	0/4+
Strength:		
Vastus medialus:	normal bulk	normal bulk
Palpable spurs:	no	no

Fig 15

310

ANKLES AND FEET:	**RIGHT**	**LEFT**
Dorsiflexion:	0-20	0-20
Plantar flexion:	0-40	0-40
Inversion:	0-10	0-10
Eversion:	0-20	0-20
Crepitation:	negative	negative
Palpable spurs:	no	no
Instability:	no	no

TOES:	**RIGHT**	**LEFT**
M.P.	0-90	0-90
Crepitation:	no	no
Palpable spurs:	no	no
Instability:	no	no
P.I.P.	0-90	0-90
Crepitation:	no	no
Palpable spurs:	no	no
Instability:	no	no
D.I.P.	0-90	0-90
Crepitation:	no	no
Palpable spurs:	no	no
Instability:	no	no

REFLEX REACTION:		
Patellar:	2+	2+
Achilles:	2+	2+

MUSCLE STRENGTH DETERMINATION:		
Hip:	5/5	5/5
Flexion:	5/5	5/5
Extension:	5/5	5/5
Internal rotation:	5/5	5/5
External rotation:	5/5	5/5
Quadriceps:	5/5	5/5
Hamstrings:	5/5	5/5
Anterior tibialis:	5/5	5/5
Gastrocnemius:	5/5	5/5
Peroneals:	5/5	5/5
Extensor hallux:	5/5	5/5
Flexor hallux:	5/5	5/5
Extensor digitorum:	5/5	5/5
Flexor digitorum:	5/5	5/5

SENSATION:	Normal	Normal

PULSES:	**RIGHT**	**LEFT**
Dorsalis pedis:	2+	2+
Posterior tibial:	2+	2+
Popliteal:	2+	2+
Femoral:	2+	2+

MEASUREMENTS:	**RIGHT**	**LEFT**
Thigh - 2" above patella		
4" above patella		
6" above patella		
Calf (at maximum circumference:		
Leg length:		

Fig 16

312

X-RAY

LOCATION	# OF VIEWS (1-5)	N/A
_____	_____	___
_____	_____	___
_____	_____	___
_____	_____	___

A-Cervical spine B-Thoracic spine C-Lumbar spine D-Shoulders

E-Humerus F-Elbow G-Forearm H-wrist I-Hand J-Thumb

K-Finger L-Hip M-Femur N-Knee O-Tibia P-Ankle Q-Foot

ABNORMALS: A B C

Cervical, Lumbar and Thoracic spine:
Alignment is normal/abnormal.
Paravertebral soft tissues are normal/abnormal.
Lordosis is normal/abnormal.
The intervertebral disc spaces are maintained/narrow.
Evidence of congenital: yes/no
Evidence of degenerative: yes/no
Evidence of post-traumatic abnormalities: yes/no

Other _____

OTHER:
The bony contours are normal/abnormal.
Consistency is normal/osteoporotic/abnormal.
The cortex is intact/disrupted.
Disrupted at _____
Joint surfaces are:

Contour:	Normal	Irregular
Height:	Normal	Narrowed
Spurs:	Present	Absent

Other _____

FRACTURES:

1. The fracture alignment is satisfactory.
2. The fracture alignment is satisfactory with good callus.
3. Free bodies.
4. Retained surgical metal.

Fig 17

314

DIAGNOSIS:

The patient was instructed in a home exercise program? yes no
PHYSICAL THERAPY: Ordered Continued Changed Discontinued None
L-Lumbar program C-Cervical Program B-Back School E-electrostim
I-Iontophoresis Q-Quadriceps Program R-Range of Motion
S-Strengthening K-Knee O-Other
_____times for _____ weeks.
_____Surgery
was discussed in detail, including complications, alternatives and prognosis.
Scheduled at/for_____
Chiropractic care was discussed with patient?: _____Y/N
Medication prescribed:_____
Testing ordered:_____
_____
Referral initiated or requested to _____
for _____

DISCUSSION:

CURRENT STATUS:
A. Working without limitations B. Working with limitations _____
C. Not working R. Retired S. Student
K. Child H. Housewife
If the patient is not working:
D. Released for work on _____(date)
E. Estimated time before released for work. _____#_____ W M

DISABILITY STATUS:
A. Temporarily partially disabled with no expectation of permanent disability.
F. Temporarily partially disabled with expectation of some level of permanent disability.
B. Temporarily totally disabled.
C. Permanent and stationary with no disability.
D. Permanent and stationary with rateable disability.
E. Permanent and stationary with permanent factors of disability.

VOCATIONAL REHABILITATION:
A. There is a need for vocational rehabilitation. yes/no
B. There is no need for vocational rehabilitation. yes/no
C. The need for vocational rehabilitation cannot be determined at this time.

RETURN VISIT:_____D for Days____W for Weeks____M for Month PRN
Reason for return visit: X-ray COX Recheck Suture removal
Staple removal Test results Surgery Video Review Post Op H & P

Fig 18

330

DATE

NAME
ADDRESS
STATE ZIP

Re:
Emp:
DOI:
SS#:
CL#:

Dear Sir/Madam:

HISTORY: The patient is a XX-year-old Caucasian female who is returning for a postoperative visit, regarding complaints referable to the knee. The patient was injured in a work related accident on XX/XX/XX. The patient was last seen on XX/XX/XX. The patient underwent an arthroscopy, partial lateral and medial meniscectomy, and chondral debridement of the right knee on XX/XX/XX.

CURRENT COMPLAINTS: The right knee pain is a dull aching type. Other symptoms include: stiffness, soreness, numbness, and swelling. Her pain is improved by ice. Her pain is made worse by standing, walking, and bending.
The patient has night pain which renders her unable to sleep.

SPECIAL STUDIES: None.
ALLERGIES: No known drug allergies.
CURRENT MEDICATION: Motrin.

PHYSICAL EXAMINATION:
KNEE EXAMINATION: Right
Flexion/Extension: 0-120 degrees

X-RAY: None taken today.

DIAGNOSIS:
836.0 Medial meniscus tear, post arthroscopy, partial medial meniscectomy with chondral debridement, right knee.
836.1 Lateral meniscus tear, post arthroscopy, partial lateral meniscectomy, right knee.
716.96 Osteoarthritis of the right knee.

Fig 19

330

DISCUSSION: The treatment program was reviewed. Physical therapy has been continued to include: strengthening, range of motion, and knee program 3 times a week for 3 weeks. Present medication prescribed: Vicodin. I have given the patient a prescription for a thermophore for her lumbar spine pain, due to physical therapy for the right knee.

CURRENT STATUS: The patient is not working.

DISABILITY STATUS: The patient is temporarily totally disabled.

RETURN VISIT: The patient will return in 1 week for a post-op visit.

Sincerely,

Fig 20

DATE
NAME
ADDRESS
STATE ZIP

338

XX/XX/XX
RE:

HISTORY: The patient is a XX-year-old Caucasian male who is returning for a follow-up visit, regarding complaints referable to the hips. The patient was last seen on XX/XX/XX. Since his last visit he has taken a Medrol Dose Pack.

CURRENT COMPLAINTS: The patient denies any right hip pain. This has improved since his last visit.

The patient's left hip pain is a dull aching type. Other symptoms include soreness. This has improved since his last visit. His pain is improved by rest and medication. His pain is made worse by sitting, lifting, twisting, bending, and walking.
The patient does not have night pain which awakens him.

SPECIAL STUDIES: None.

ALLERGIES: Codeine and Penicillin.

CURRENT MEDICATION: Antibiotics, Lanoxin, and Tagamet.

PHYSICAL EXAMINATION:

HIPS:	Right	Left
Flexion:	0-90	0-90 degrees

Areas of tenderness: ischial tuberosity, left
Areas of erythema: none
Areas of swelling: none
Areas of ecchymosis: none

X-RAY: None taken today.

DIAGNOSIS:
912.00 Abrasion of the left arm, healed.

716.95 Osteoarthritis, post total hip arthroplasty, left.

820.21 Greater trochanter fracture, right hip.

DISCUSSION: The treatment program was reviewed. No physical therapy was ordered.

CURRENT STATUS: The patient is retired.

RETURN VISIT: The patient will return in 2 weeks for a follow-up visit.

Fig 21

342

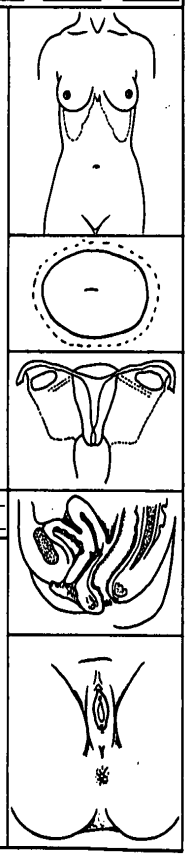
INITIAL EXAM AND ANNUAL UPDATE

NAME_____

AGE_____DATE_____

Physical Examination	Height	Weight	B.P.	LMP	Gra_____Para_____SAB_____

Pelvic Exam	Normal	Abn	NE	Check and detail all positive findings below.
1. Ext. genitalia				
2. Vagina				
3. Cervix				
4. Uterus (describe)				
5. Adnexa				
6. Rectum				
7. Other				
General Physical				
8. Skin				
9. HEENT				
10. Neck				
11. Chest				
12. Breasts				
13. Heart				
14. Lungs				
15. Abdomen				
16. Musculoskeletal				
17. Extremities				
18. Neurologic				



LAB PERFORMED: HCT____UA____ CULTURE: URINE HERPES BIOCULT CHLAMYDIA____

PAP_____WET MOUNT_____LABSCAN_____PREG._____OTHER:_____

Diagnosis and Treatment Plans

Fig 22

344

NAME: DATE: INIT:

This ____ year old G __ P __ A __ T __ o new o returning pt is here for:

- o Annual exam and pap smear
- o Recheck of : _____
- o _____ procedure for _____
- o Pre-op o Post-op visit for _____ Date / /

Her LMP was / / , cycles are o reg every _____ days o irreg (describe)

- o 19 __ due to natural onset of menopause.
- o 19 __ Status/post o TAH o TVH o BSO for: _____

She has complaints of:
(signs/symptoms)
(type/duration)
(home/other tx)
(other info)

She is also concerned/has questions regarding :

1* Her birth control method is: o BCP'S ____
- o BTL/hyst o Depo-Provera
- o vasectomy o Norplant o abstinence
- o condoms o none o trying for pregnacy

2* She currently is / is not on ERT.

Last annual & pap date and results / / o WNL o Abn

Past medical and operative hx was reviewed.
Significant finding include:
(Chronic/Serious Illness)
(Previous operations)

She see's Dr. _____
for problems # 1 2 3 4 5

Dr. _____is her family phy.

1.
2.
3.
4.
5.

1. _____ CURRENT MEDS & DOSAGES
2. _____
3. _____
4. _____
5. _____

Fig 23

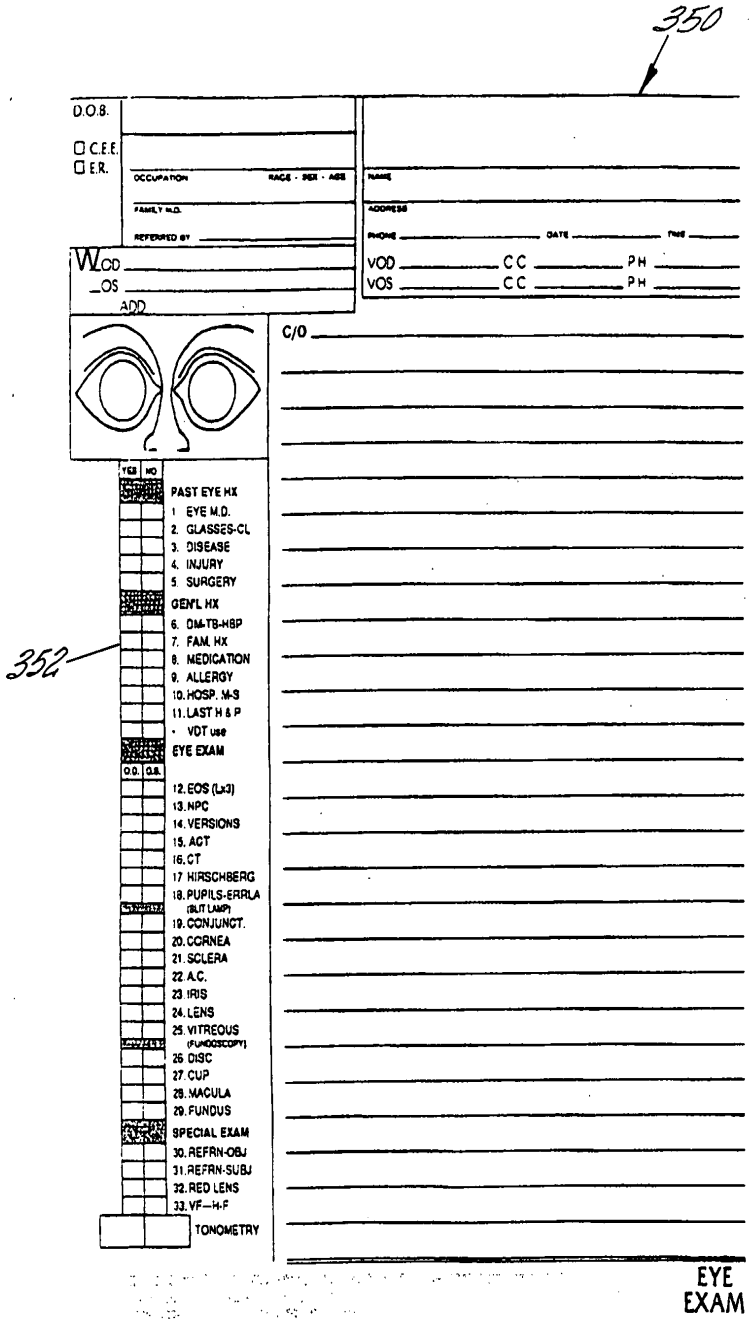


Fig 24

356

WORKER'S COMPENSATION HISTORY

PATIENT'S NAME _____

ADDRESS _____
street address city zip code

HOME PHONE _____ DATE OF BIRTH _____

MARITAL STATUS _____ SEX___ AGE___ RIGHT OR LEFT HANDED_____

NUMBER OF CHILDREN LIVING AT HOME _____

SOCIAL SECURITY NUMBER _____

OTHER NAMES USED PREVIOUSLY _____

PATIENT REFERRED BY: (i.e. insurance co., physician, attorney, state of California) include address:

EMPLOYER at time of accident _____

ADDRESS _____
street address city zip code

HOW LONG WERE YOU EMPLOYED: _____

NUMBER OF HOURS AND DAYS WORKED PER WEEK: _____

JOB DESCRIPTION: _____

JOB ACTIVITIES: _____

SITE OF ACCIDENT IF DIFFERENT FROM ABOVE: _____

ACCIDENT DATE: _____ ACCIDENT TIME: _____

DATE FIRST TREATED:_____ WERE YOU DRIVING A COMPANY VEHICLE__

DATE LAST WORKED: _____

DATE RETURNED TO WORK: _____

Fig 25

358

ARE YOU PRESENTLY WORKING: YES__ NO__

WORK RESTRICTIONS, IF ANY: _____

PRESENT EMPLOYER: _____

ADDRESS: _____
street address city zip code

DATE OF EMPLOYMENT: _____

PHONE: _____

JOB DESCRIPTION _____

JOB ACTIVITIES _____

HISTORY OF THE ACCIDENT:

Describe fully the accident: _____

Describe any equipment and/or machinery involved: _____

Describe your physical complaints immediately following this accident:

Head: _____

Neck: _____

Back: _____

Arms: _____

Legs: _____

Fig 26

360

Did you report the injury to your employer? Yes__ No__

To whom and when did you report this injury? _____

Were you treated at the company dispensary, given first aid, or sent elsewhere? _____

Name and addresses of witnesses to the accident _____

How did you get to a place of treatment? _____

Did you go home or continue working? Yes___ No___

TYPE OF TREATMENT RECEIVED SINCE THE ACCIDENT: (include hospital, surgeries, physical therapy, chiropractic therapy or any other treatment)

DOCTOR OR FACILITY	WHEN SEEN	NATURE OF TREATMENT	DID TREATMENT HELP? Y N	X-RAYS TAKEN Y N

Other tests performed: (MRI, CT scans, arthrogram, EMG)

Yes ___ No ___

List where tests were performed below:

_____

_____

_____

Fig 27

362

What medications have been prescribed and give results:

MEDICATION RESULTS

DIAGNOSIS GIVEN:

Describe fully all present complaints:

COMPLAINT	(IMPROVED/WORSE/UNCHANGED)	PAIN RATING (0-10)
Head:		
Neck:		
Back:		
Arms:		
Legs:		

IF YOU HAVE HEADACHES PLEASE ANSWER THE FOLLOWING QUESTIONS:

How often do you have headaches?

How long do they last?

Do you have
(circle appropriate symptom(s)) Light-headedness, ringing in ears, visual blurring, nervousness, or trouble sleeping.

Fig 28

364

What part of your head hurts?

What (if any) medications do you take for the headache and how often do you take them?

IF YOU HAVE NECK PAIN PLEASE ANSWER THE FOLLOWING QUESTIONS:

(circle appropriate symptom(s)) bending head forward, looking up, turning head from side to side, reaching up, lifting, pushing, or pulling.

IF YOU HAVE BACK PAIN, PLEASE ANSWER THE FOLLOWING QUESTIONS:

How long can you sit in one place before the back pain becomes intolerable?

How long can you stand in one place before the back pain is intolerable?

How long can you walk before the back pain is intolerable?

How long can you remain bent over to do repeated bending before the back pain is intolerable?

What is the greatest weight you can lift without increasing your back pain?

Does overhead work, reaching, pushing or pulling cause an increase in the back pain?

Fig 29

366

Does the pain go into your arms or legs, if yes, which ones

_____

and what activities cause this to occur?_____

_____

_____

Do you experience numbness in the legs, if yes (does it)

1. travel down the front of the legs?_____
2. travel down the back of the legs? _____
3. travel into the toes, if yes, which ones_____
4. is the numbness present constantly_____
5. when did this symptom start_____

ALL PATIENTS PLEASE ANSWER THE FOLLOWING QUESTIONS:

What medications are you currently taking?_____

_____

_____

Do you have other mental, physical, or emotional problems which might have caused, been aggravated, or resulted from this accident?

_____

_____

RESTRICTED SOCIAL ACTIVITIES:

List any social/sports activities that you can no longer do or have had to significantly limit due to this injury (i.e.: housework, gardening, child care)

ACTIVITY _____ DESCRIBE HOW YOU ARE RESTRICTED

_____

_____

_____

Fig 30

368

PRIOR WORK RELATED INJURIES:

List prior or past illnesses and/or surgeries. List name and addresses of employers (include dates and nature of injury, fractures, lacerations, contusions, auto accidents).

_____

_____

_____

_____

_____

List dates you stopped working because of this accident. _____

_____

Did you return to work? Yes___ No___

If so, date you returned to work? _____

Work restrictions if any? _____

_____

Fig 31

370

PAST MEDICAL HISTORY: -- Indicate if you have had any of the following:

	Yes	No
Measles, Mumps, Chickenpox		
Eye Problems		
Ear, Nose, Throat Problems		
Respiratory Problems		
Cancer		
Heart Disease		
High Blood Pressure		
Arthritis		
Gout		
Urinary/Kidney Problems		
Liver Disease		
Stroke		
Diabetes		
Epilepsy		
Circulation Problems		
Stomach/Ulcer Problems		
Alcoholism/Drug Abuse		
Psychological Problems		

Industrial Injuries -- Have you ever been injured on the job other than what you are being examined for today?

Yes___ No___

If yes, please list below:

YEAR	EMPLOYER	INJURED AREA	DID YOU RECOVER?	IF NOT, DESCRIBE

Fig 32

372

PRIOR PERSONAL INJURIES:

Automobile Accidents -- Please indicate if you have ever been involved in one either before or after the date of accident for which you are being seen.

Yes___ No___

If yes, please list below:

YEAR	INJURED AREA/BODY PART	DID YOU RECOVER?	IF NOT, DESCRIBE

Other Injuries -- List any major accidents/injuries other than listed above (includes broken bones).

YEAR	INJURED AREA/BODY PART	DID YOU RECOVER?	IF NOT DESCRIBE

Surgeries -- List any surgeries you have had performed.

YEAR	AREA OF BODY	DID YOU RECOVER?	IF NOT, LIST REASON

List any allergies to foods or medications _____

_____

If you smoke cigarettes how long have you smoked and how much do you smoke? _____

Fig 33

374

If you drink alcohol how much do you routinely consume? _____

_____

EDUCATION HISTORY:

_____

_____

Fig 34

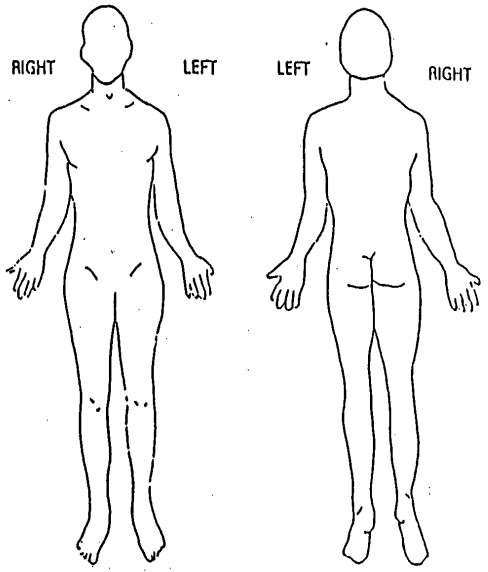
376

PAIN DIAGRAM

Using the figures below, mark the areas where you feel the described sensations are on your body. Use the appropriate symbol(s) and include all the affected areas.

Dominant hand: __ Left __ Right

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
+ + + +	= = = = =	0 0 0 0 0	V V V V V	/ / / / /
+ + + +	= = = = =	0 0 0 0 0	V V V V V	/ / / / /



PLEASE SELF RATE YOUR PAIN BY BODY PART, BASED ON A SCALE OF 0-10, 10 BEING THE WORST PAIN YOU HAVE EVER EXPERIENCED, WHAT IS YOUR PAIN LEVEL TODAY.

BODY PART _____ PAIN LEVEL_____
BODY PART _____ PAIN LEVEL_____
BODY PART _____ PAIN LEVEL_____
BODY PART _____ PAIN LEVEL_____

Fig 35

378

Jobs Held In The Past

Starting with the most recent:

DATE	EMPLOYER	JOB TITLE	DUTIES
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

Did you have any injuries or receive medical treatment at these jobs (Workers' Compensation Disability payments)? Yes___ No___

If yes, when? _____

Where? _____

Thank you for helping us with your history.

Form completed by: _____ Date: _____
Signature

Assisted by: _____

Fig 36

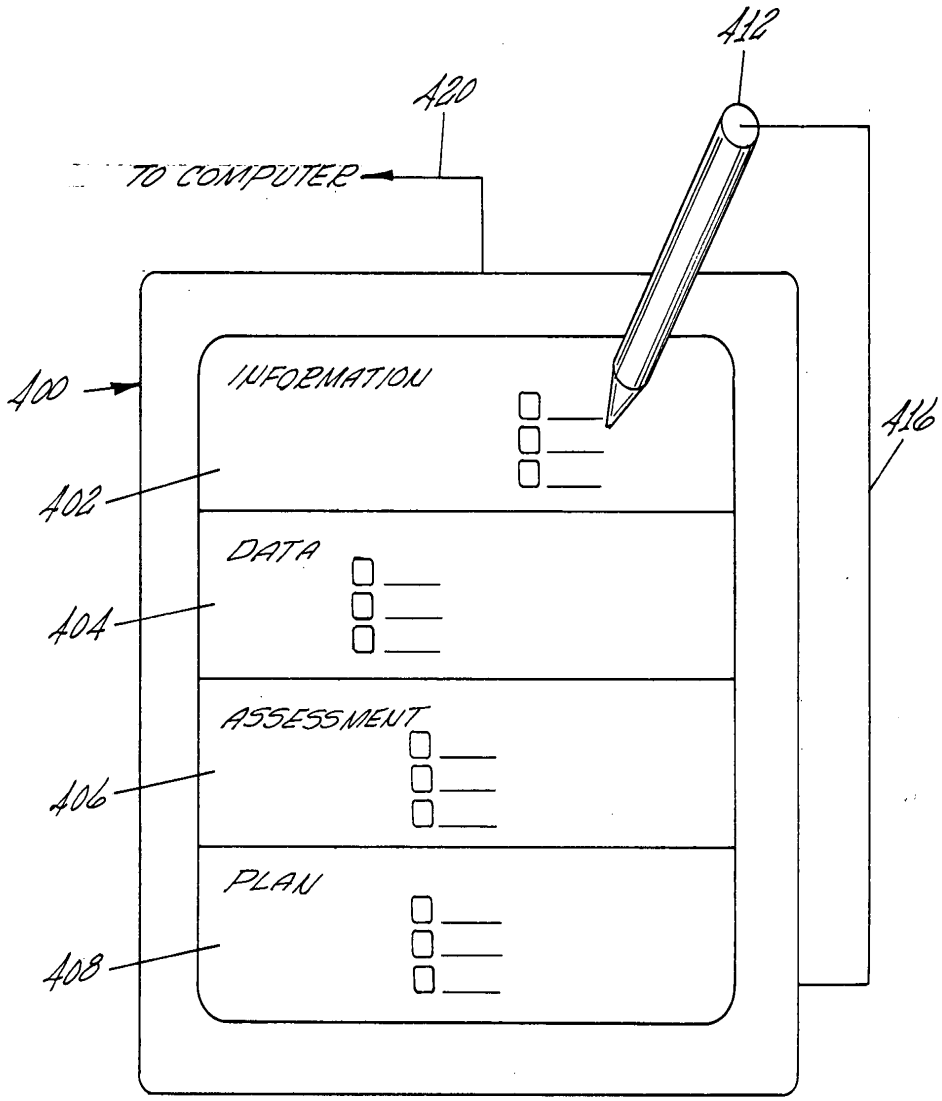


Fig 37